

Patient History Form

Patient's Name _____

Date of Birth _____

Please answer the following questions about your medical status and history.

<p>1. Have you ever been treated for any Medical Conditions? (E.g. Diabetes, High blood pressure, Arthritis, etc.)?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES, If yes please list:</p> <p>_____</p> <p>_____</p>	<p>5. Family and Social History Do you have any medical or eye diseases that run in your family?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES, If yes please list:</p> <p>_____</p> <p>_____</p>
<p>2. Have you ever had any Eye Disease? (E.g. Glaucoma, Cataract, "Lazy Eye", Retinal Detachment)?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES, If yes please list:</p> <p>_____</p> <p>_____</p>	<p>6. Do you smoke?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES, If yes how much?</p> <p>_____</p>
<p>3. Have you ever had any Surgeries?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES, If yes please list:</p> <p>_____</p> <p>_____</p>	<p>7. Do you consume any Alcohol?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES, If yes how much?</p> <p>_____</p>
<p>4. Have you ever been other than surgeries Hospitalized?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES, If yes please list:</p> <p>_____</p> <p>_____</p>	<p>8. Do you consume any products with caffeine?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES, If yes how much?</p> <p>_____</p>
<p>Do you have any allergies? (Food, drug, or other)</p> <p>_____</p> <p>_____</p>	
<p>9. Medications: (including any eye medications)</p> <p>_____</p> <p>_____</p> <p>_____</p>	

Review of Systems

Do you Currently have any of the following problems?

	YES	NO	if YES, please explain:
⇒ Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
⇒ Ear/nose/throat problems (hearing loss, sinus, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
⇒ Heart problems (chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
⇒ Respiratory problems (shortness of breath, wheezing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
⇒ Gastrointestinal problems (heartburn, abdominal pain, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	_____
⇒ Urinary problems (pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
⇒ Skin problems (rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
⇒ Musculoskeletal problems (muscle aches, joint pain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
⇒ Neurologic problems (numbness, weakness, headaches)	<input type="checkbox"/>	<input type="checkbox"/>	_____
⇒ Psychiatric problems (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient's Signature _____

Date _____

Physician's Signature _____

Date _____

